

SERFF Tracking Number: MGCC-126170868 State: Arkansas
Filing Company: The Mega Life and Health Insurance Company State Tracking Number: 42520
Company Tracking Number: CH/MG-25098-APP NN (03/09) - (FOR MEGA)
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: CH/MG Combo App (03/09)
Project Name/Number: CH/MG Combo App (03/09)/CH/MG-25098-APP NN (03/09)

Filing at a Glance

Company: The Mega Life and Health Insurance Company

Product Name: CH/MG Combo App (03/09) SERFF Tr Num: MGCC-126170868 State: ArkansasLH
TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 42520
Sub-TOI: H21.000 Health - Other Co Tr Num: CH/MG-25098-APP NN State Status: Approved-Closed
(03/09) - (FOR MEGA)
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Authors: Courtney Sharp, Chalon Disposition Date: 06/03/2009
Ybarra, Jaime Butler
Date Submitted: 05/29/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: CH/MG Combo App (03/09) Status of Filing in Domicile:
Project Number: CH/MG-25098-APP NN (03/09) Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type:
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 06/03/2009 Explanation for Other Group Market Type:
State Status Changed: 06/03/2009
Deemer Date: Corresponding Filing Tracking Number:
Filing Description:
Application Form CH/MG-25098-APP NN (03/09)

Company and Contact

Filing Contact Information

SERFF Tracking Number: MGCC-126170868 State: Arkansas
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Chalon Ybarra, Compliance Analyst II chalon.ybarra@healthmarkets.com
9151 Boulevard 26 (817) 255-5487 [Phone]
North Richland Hills, TX 76180 (817) 255-8153[FAX]

Filing Company Information

The Mega Life and Health Insurance Company CoCode: 97055 State of Domicile: Oklahoma
9151 Boulevard 26 Group Code: 264 Company Type: Health
North Richland Hills, TX 76180 Group Name: State ID Number:
(817) 255-3100 ext. [Phone] FEIN Number: 59-2213662

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Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: \$20.00 per form x 1 form = \$20.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Mega Life and Health Insurance Company	\$20.00	05/29/2009	28195237

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/03/2009	06/03/2009

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Disposition

Disposition Date: 06/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	List of Forms	Approved-Closed	Yes
Supporting Document	Exhibit A	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CH/MG-25098-APP NN (03/09)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CH/MG-25098-APP NN (03/09)	Application/ Enrollment Form	Application/ Enrollment Form	Initial		50	CHMG-25098-APP NN_0309_.pdf

7. Occupation/duties of Primary Applicant: _____ Spouse Applicant: _____
8. Is any Applicant eligible for or covered under Medicare or Medicaid? ___ Yes ___ No. If "Yes," who? _____
Reason: Financial _____ Medical _____
9. a) Does any applicant currently have **health** insurance or has any applicant had health insurance within the past 12 months? ___ Yes ___ No. If "Yes," ___ Group or ___ Individual coverage? If "Yes," list applicant(s) and names of companies, certificate/policy number and types of coverage: _____

If "Yes" has coverage been in force within the past 60 days? ___ Yes ___ No. If "No", date of cancellation: _____

If "Yes", will existing **health** coverage be replaced or changed if proposed **health** coverage is issued? ___ Yes ___ No. If "No," reason: _____
9. b) Do you currently have **life** insurance or **annuities**? ___ Yes ___ No. If "Yes," will the insurance applied for replace or otherwise reduce in value any **life** insurance or **annuities** now in force? ___ Yes ___ No. If "Yes," list details: _____

TO BE ANSWERED BY AGENT:

Do you have any knowledge or reason to believe that the proposed Insured(s) is intending to replace or otherwise reduce in value any existing **life** insurance or **annuities**? ___ Yes ___ No. **AGENT'S INITIALS:** _____

Questions 10 – 20 are NOT applicable for the Dental Insurance Policy, form series 26099-IP (1/08), and/or the Vision Insurance Policy, form series 26023-IP (05/07), only. They are applicable for all other plans applied for herein.

10. a) Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? ___ Yes ___ No. If "Yes," who? _____ Estimated date of delivery _____
- b) Is the Applicant, spouse, or any dependent child (even if not proposed for insurance) being tested for or receiving treatment for fertility/infertility, in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage)?
_____ Yes ___ No. If "Yes," who? _____ Provide Details _____
11. Does any Applicant to be insured engage in any hazardous sport or activity? (e.g.: flying, diving, skydiving, racing.) ___ Yes ___ No. If yes, is it professionally or for recreation? _____
Name: _____ Activity _____
12. During the past two years, has any person to be insured had insurance declined, postponed, had a waiver applied, or charged additional premium for life, disability or health insurance or had such insurance rescinded??
___ Yes ___ No. If "Yes," who? _____ Date: _____
Reason: _____ Company: _____
13. Name of current doctor and any other doctor or specialist seen in the past 12 months:
- a) Applicant's Doctor/Specialist _____ Phone Number (_____) _____ - _____
Address _____ City _____ State _____ Zip _____
- b) Spouse's Doctor/Specialist _____ Phone Number (_____) _____ - _____
Address _____ City _____ State _____ Zip _____
- c) Child(ren)'s Doctor/Specialist _____ Phone Number (_____) _____ - _____
Address _____ City _____ State _____ Zip _____
14. Has any Applicant used tobacco products in the **past twelve (12) months**? ___ Yes ___ No. If "Yes," who? _____
Provide smoking/tobacco history over the past twelve (12) months: _____
15. a) Has any Applicant ever had or currently has a suspended or revoked Driver's License? _____ Yes _____ No.
If "Yes," who? _____ Reason(s)? _____
- b) Has any Applicant ever received any citations for driving while under the influence? _____ Yes _____ No.
If "Yes," who? _____ How many DWIs/DUIs? _____
Date(s) of citation(s): _____
- c) Has any Applicant ever been convicted or prosecuted for any criminal activity? _____ Yes _____ No.
If "Yes," who? _____ List details: _____
16. a) When was the last time the Applicant visited a doctor/specialist/urgent care/hospital? _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
- b) When was the last time the spouse visited a doctor/specialist/urgent care/hospital? _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
- c) When was the last time the child(ren) visited a doctor/specialist/urgent care/hospital?
Child's Name: _____ Date(s): _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
Child's Name: _____ Date(s): _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____

Child's Name: _____ Date(s): _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
Child's Name: _____ Date(s): _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____

17. Have you or any Applicant **EVER** had symptoms, been diagnosed, received medical advice or been treated for (if "Yes," select all applicants this applies to and show details below):

FAMILY MEMBERS

- a) **Heart or Cardiovascular Conditions/Disorders, including but not limited to:** Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system? Yes No 1 2 3 4 5 6 7 8 9 10
- b) **Endocrine Disorders, including but not limited to:** Diabetes (high blood sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity? Yes No 1 2 3 4 5 6 7 8 9 10
- c) **Blood Disorders, including but not limited to:** Blood or spleen disorder, including anemia, leukemia, high cholesterol or hyperlipidemia? Yes No 1 2 3 4 5 6 7 8 9 10
- d) **Gynecological Disorders, including but not limited to:** male or female reproductive organ disorder or disease, including breast disorder or augmentation? Yes No 1 2 3 4 5 6 7 8 9 10
- e) **Cancer / Tumor or any benign or malignant growths, including but not limited to:** Cancer, cyst, tumor, or neoplasm? Yes No 1 2 3 4 5 6 7 8 9 10
- f) **Respiratory Disorders, including but not limited to:** Respiratory disorder, including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea or breathing problems? Yes No 1 2 3 4 5 6 7 8 9 10
- g) **Urinary Tract Disorders, including but not limited to:** Kidney, bladder, urinary tract, stones, or prostate disorders? Yes No 1 2 3 4 5 6 7 8 9 10
- h) **Digestive Tract Disorders, including but not limited to:** GERD, Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis, hepatitis, or pancreatitis? Yes No 1 2 3 4 5 6 7 8 9 10
- i) **Colon Disorders, including but not limited to:** Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders? Yes No 1 2 3 4 5 6 7 8 9 10
- j) **Eye, ear, nose, or throat disorders?** Yes No 1 2 3 4 5 6 7 8 9 10
- k) **Skin Disorders, including but not limited to:** Skin disorders, burns, lacerations, dermatitis, boils, chronic rashes, or melanoma? Yes No 1 2 3 4 5 6 7 8 9 10
- l) **Musculoskeletal Disorders, including but not limited to:** Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis? Yes No 1 2 3 4 5 6 7 8 9 10
- m) **Complications of Pregnancy, including but not limited to:** Cesarean section? Yes No 1 2 3 4 5 6 7 8 9 10
- n) **Brain Disorders, including but not limited to:** epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches? Yes No 1 2 3 4 5 6 7 8 9 10
- o) **Mental and Nervous Disorders, including but not limited to:** depression, anxiety, alcoholism, alcohol abuse, drug abuse or drug addiction? Yes No 1 2 3 4 5 6 7 8 9 10
- p) **Connective Tissue Disorders, including but not limited to:** Hodgkin's or Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue disease? Yes No 1 2 3 4 5 6 7 8 9 10
- q) **Abnormal Test Results, including but not limited to:** cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray? Yes No 1 2 3 4 5 6 7 8 9 10
- r) **Symptoms of other Medical Conditions, including but not limited to:** Abnormal pain or bleeding, swollen or enlarged prostate, or night sweats? Yes No 1 2 3 4 5 6 7 8 9 10

s) **Muscular Disorders, including but not limited to:** Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of use of any limbs? Yes No 1 2 3 4 5 6 7 8 9 10

t) **AIDS / HIV** - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an AIDS-related test? Yes No 1 2 3 4 5 6 7 8 9 10

18. Have you or any Applicant(s) WITHIN THE LAST 5 YEARS, had any other medical or surgical advice, hospitalizations, treatment, operations, or testing? Yes No 1 2 3 4 5 6 7 8 9 10

19. In the past 3 years, have you or any applicant taken, been advised to take, or been prescribed any medication(s), including any which were not filled? Yes No 1 2 3 4 5 6 7 8 9 10
If yes, what condition(s) is the prescribed medication(s) for?

20. Have you or any Applicant(s) been advised to have additional testing, lab work, surgical or medical treatment or had such that has not yet been completed? Yes No 1 2 3 4 5 6 7 8 9 10

Questions 21 through 23 are ONLY required to be answered if applying for the "MEGA Critical Care/Plus Plan" (Specified Disease/Condition or Major Organ Transplant Certificate, form 25936-C):

21. **Family History** - Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or diabetes? If "Yes", please complete the chart below. Yes No 1 2 3 4 5 6 7 8 9 10

FAMILY RECORD OF PROPOSED INSURED

	IMPAIRMENT	AGE AT ONSET	AGE AT DEATH
Father			
Mother			
Brothers			
Sisters			

22. **Transplant** - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? Yes No 1 2 3 4 5 6 7 8 9 10

23. **Critical Illness** - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke, disease of the heart or blood vessels, renal failure, multiple sclerosis, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or Alzheimer disease? Yes No 1 2 3 4 5 6 7 8 9 10

Question 24 is ONLY required to be answered if applying for
the "MEGA Income Protection Plan" (Accident-Only Disability Income Insurance Certificate, form 25916-C) or
the "MEGA Income Protection Plus Plan" (Disability Income Insurance Certificate, form 25915-C):

24. a) Do you currently have Disability Income Insurance (either through your employer or as an individual policy)?
 ___ Yes ___ No. If "Yes," please provide the following additional information:

Company	Monthly Benefit	Elimination Period	Length of coverage

- b) Are you currently disabled or receiving disability benefits? _____ Yes _____ No
- c) What is your annual gross income? \$_____
- d) How many hours per week do you work? _____ hours
- e) Tell us your occupation and describe your specific job duties? _____

- f) As part of your normal activities, do you spend more than 25% performing manual labor/duties such as lifting, bending, stooping, pulling, pushing and/or carrying objects over 10 pounds? _____ Yes _____ No

COMPLETE THE FOLLOWING FOR ANY "YES" ANSWER TO QUESTIONS 17 THRU 20 AND ATTACH TO THE APPLICATION

Name	Nature of Illness or Accident (include symptoms, diagnosis(es), operation(s), and medication(s))	Date Started	Date Stopped	Operation	Hospitalized	Doctor's Name and Address
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the certificate/policy is delivered to the Applicant *while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.*

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

I have received and understand the Notification of Consumer Report and Medical Information Bureau Pre-Notice.

Signed _____ / _____ / _____ at _____, _____ State
Date City

X _____ X _____
Signature of Applicant Signature of Spouse (If to be covered)

TO BE ANSWERED BY AGENT:

I certify that each question on this application was asked by me of the Applicant(s) named above, and all answers are accurately recorded.

X _____
Signature of Licensed Agent Print Full Name Agent Number

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 06/03/2009
Comments:
Attachments:
 AR.MEGA.CH.MG-25098-APP.NN._0309__Cert.Compl.Rule-Reg19.pdf
 AR.MEGA.CH.MG-25098-APP.NN._0309__flesch.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 06/03/2009
Comments:
 This submission is for a new application.

Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 06/03/2009
Bypass Reason: N/A - Application only filing
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 06/03/2009
Bypass Reason: N/A - Application only filing
Comments:

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 06/03/2009
Comments:
Attachment:
 AR.MEGA.CH.MG-25098-APP.NN._0309__Cover.Letter.pdf

Satisfied -Name: List of Forms **Review Status:** Approved-Closed 06/03/2009
Comments:
Attachments:

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AR.CLICO CH.MG-25098-APP NN _0309__List of Forms.pdf

AR.MEGA CH.MG-25098-APP NN _0309__List of Forms.pdf

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Satisfied -Name: Exhibit A

Review Status:

Approved-Closed

06/03/2009

Comments:

Attachment:

Exhibit A [Mktg Pgs].pdf

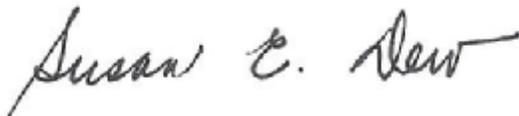
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The MEGA Life and Health Insurance Company

Form Number(s):

CH/MG-25098-APP NN (03/09)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Susan Dew

Name

Senior Vice President, Associate General Counsel and Chief Compliance Officer

Title

May 29, 2009

Date

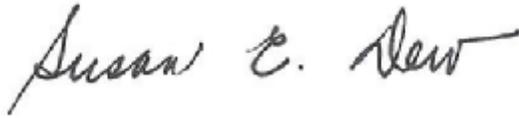
Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name: Application

Form Number: CH/MG-25098-APP NN (03/09)

Flesch Reading Ease Score: 50



Susan Dew
Senior Vice President, Associate General Counsel and Chief Compliance Officer
The MEGA Life and Health Insurance Company

May 29, 2009

Date

May 29, 2009

Commissioner Jay Bradford
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201

RE: The MEGA Life and Health Insurance Company
NAIC No. 264-97055 **FEIN No. 59-2213662** **SERFF Tracking # MGCC-126170868**

Form Number:
CH/MG-25098-APP NN (03/09)

Description:
Application for Insurance

Supporting Documentation:
EXHIBIT A
FORMS LISTING
FORMS LISTING

Marketing / Product Selection Information
Chesapeake Forms Listing
MEGA Forms Listing

Dear Commissioner Bradford:

The above referenced form, **CH/MG-25098-APP NN (03/09)**, is submitted for your review and approval. This form is new and not intended to replace any forms currently approved by your Department.

The above referenced form, "Exhibit A", is hereby submitted as supporting documentation for informational purposes only. It is intended to be used in conjunction with the Application for Insurance form CH/MG-25098-APP NN (03/09), and represents the manner in which:

- Ancillary certificates and policies underwritten and previously approved under The MEGA Life and Health Insurance Company will be presented to applicants; and
- Health policies and accompanying riders, as well as ancillary policies underwritten and previously approved under our sister company, The Chesapeake Life Insurance Company, will be presented to applicants.

This application form is intended to be used to solicit coverage at this time under the policy / certificate forms specified on the attached Forms Listings. It is also our hope that we may be granted the flexibility to solicit coverage using this application for any policies or certificates approved in the future.

To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

If you have any questions or if anything further is needed to expedite the review of this filing, please email or call collect. Your assistance in this matter is greatly appreciated.



Sincerely,

Chalon Ybarra

Chalon Ybarra
Product Compliance Analyst II
Compliance Department

HealthMarkets®

9151 Boulevard 26 • North Richland Hills • TX 76180
P (817) 255-5487 • F (817) 255-8153
chalon.ybarra@HealthMarkets.com • www.HealthMarkets.com

**The Chesapeake Life Insurance Company
FORMS LISTING**

List of policy /rider forms approved by Colorado that CH/MG-25098-APP NN (03/09) CO
will be used to solicit coverage under:

FORM NUMBER	FORM TYPE	APPROVAL DATE	SERFF ID
CH-26210 PPO-IP (03/09) AR	Catastrophic Expense Preferred Provider Organization (PPO) Policy	Pending	MGCC-126119576
CH-26220 PPO-IP (03/09) AR	Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy	Pending	MGCC-126116540
CH-26221-IR (03/09)	Outpatient Accident Expense Benefit Rider	Pending	MGCC-126137840
CH-26205-IR (08/08)	Rate Guarantee Rider	10/13/2008	MGCC-125852832
CH-26222-IR (03/09) AR	Prescription Drug Expense Rider	Pending	MGCC-126116540
CH-26223-IR (03/09)	Physician Office Services Benefit Rider	Pending	MGCC-126137840
CH-26224-IR (03/09)	Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider	Pending	MGCC-126137840
CH-26225-IR (03/09) AR	Continued Care Benefit Rider	Pending	MGCC-126137840
CH-26226-IR (03/09)	Outpatient Diagnostic Services Benefit Rider	Pending	MGCC-126137840
CH-26228-IR (03/09)	Covered Services Extension Rider	Pending	MGCC-126137840
CH-26213-IR (03/09) AR	Pregnancy/Childbirth Benefit Rider	Pending	MGCC-126137840
CH-26214-IR (03/09) AR	Prescription Drug Expense Rider	Pending	MGCC-126137840
CH-26023-IP (5/07) AR	Vision Insurance Policy	8/6/2007	MGCC-125182588
CH-26055-IP (5/07) AR	Cancer Benefit Policy	7/12/2007	MGCC-125182595
CH-26099-IP (1/08)	Dental Insurance Policy	4/22/2008	MGCC-125612182

The MEGA Life and Health Insurance Company
FORMS LISTING

List of policy/certificate forms currently approved by Arkansas that CH/MG-25098-APP NN
(03/09) AR may be used to solicit coverage under:

<u>Form Number</u>	<u>Deemer/Approval Date</u>	<u>State Tracking #</u>
25314 Accident Catastrophic Expense Plan Certificate of Insurance	08/02/1996	
25874-C Hospital Confinement Indemnity Certificate	10/13/1999	
25915-C Disability Income Insurance Certificate	03/30/2001	
25916-C Accident-Only Disability Income Insurance Certificate	11/08/2000	
25936-C Specified Disease/Condition Or Major Organ Transplant Certificate	12/03/2002	
26023-IP (5/07) AR Vision Insurance Policy	08/06/2007	35950
26038-C Accidental Injury Only Insurance Certificate	04/17/2007	35598
26055-IP (5/07) AR Cancer Benefit Policy	05/25/2007	35951
26099-IP (1/08) Dental Insurance Policy	02/20/2008	38184

The following forms are underwritten by The Chesapeake Life Insurance Company

BasicFit (Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Certificate)

(CH-26220 PPO-C (CCHBP) (03/09)) **BFIL** Family Members 1 2 3 4 5 6 7 8 9 10

Additional Plan Option Elected:
 (CH-26220 PPO-C (SSMB) (03/09)) **BFIH**

Lifetime Maximum: \$500,000 \$1,000,000

Network/Non-Network Deductible:

Per Insured Person,
per Period of Treatment

All other Outpatient Covered Services, per
Insured Person, per Calendar Year

- | | |
|---|------------------|
| <input type="checkbox"/> \$2,000/\$4,000 | \$2,000/\$4,000 |
| <input type="checkbox"/> \$3,000/\$6,000 | \$3,000/\$6,000 |
| <input type="checkbox"/> \$4,000/\$8,000 | \$4,000/\$8,000 |
| <input type="checkbox"/> \$5,000/\$10,000 | \$5,000/\$10,000 |
| <input type="checkbox"/> \$7,500/\$15,000 | \$7,500/\$15,000 |

Network/Non-Network Coinsurance: 80%/60% 70%/50%

	Hospital Inpatient & Miscellaneous Inpatient Surgeon	Outpatient Surgery Facility/ Outpatient Surgeon
<input type="checkbox"/> Option A	\$15,000/\$6,000	\$7,500/\$3,000
<input type="checkbox"/> Option B	\$20,000/\$8,000	\$10,000/\$4,000
<input type="checkbox"/> Option C	\$25,000/\$10,000	\$12,500/\$5,000
<input type="checkbox"/> Option D	\$30,000/\$12,000	\$15,000/\$6,000
<input type="checkbox"/> Option E	\$35,000/\$14,000	\$17,500/\$7,000

The following forms are underwritten by The Chesapeake Life Insurance Company

Additional Riders

Prescription Drug (CH-26222 (CCHBP/0309) or CH-26222 (SSMB/0309))

A \$50 deductible B \$250 deductible

Optional Riders

Covered Services Extension Rider (CH-26228 (SS 03/09))

Outpatient Diagnostic Services Rider (CH-26226 (SS 03/09))

Network/Non-Network Copayment Maximum per Calendar Year

\$100/\$200 \$2,500

\$100/\$200 \$5,000

\$250/\$500 \$2,500

\$250/\$500 \$5,000

Physician Office Services Rider (CH-26223 (SS 03/09)) 2 visits 4 visits

Outpatient Accident Expense Rider (CH-26221 (SS 03/09))

Copayment \$50 \$100 \$150

Maximum \$500 \$1,000 \$1,500

Outpatient Speech, Physical, & Occupational Therapy Rider (CH-26224 (SS 03/09))

Network/Non-Network Copayment: \$50/\$100 \$100/\$200

Continued Care Rider (CH-26225 (SS 03/09))

Rate Guarantee Rider (CH-26205 (SS 08/08)) 24 months 36 months

The following forms are underwritten by The Chesapeake Life Insurance Company

EssentialFit (Catastrophic Expense Preferred Provider Organization (PPO) Certificate)

(CH-26210 PPO-C (CCHBP) (03/09)) **EFIL** Family Members 1 2 3 4 5 6 7 8 9 10

Additional Plan Option Elected:

(CH-26210 PPO-C (SSMB) (03/09)) **EFIH**

Calendar Year/Lifetime Maximum:

Option A: \$1,000,000/\$2,000,000 Option B: \$1,000,000/\$4,000,000 Option C: \$2,000,000/\$8,000,000

Network /Non-Network Deductible:

\$7,500/\$15,000 (Individual)
\$15,000/\$30,000 (Family)

\$10,000/\$20,000 (Individual)
\$20,000/\$40,000 (Family)

\$15,000/\$30,000 (Individual)
\$30,000/\$60,000 (Family)

\$20,000/\$40,000 (Individual)
\$40,000/\$80,000 (Family)

Network/Non-Network Coinsurance:

100%/70% 90%/60% 80%/50%

Additional Riders

- Outpatient Diagnostic Services Rider (CH-26226 (SS 03/09))
- Outpatient Speech, Physical, and Occupational Therapy Rider (CH-26224 (SS 03/09))
- Continued Care Rider (CH-26225 (SS 03/09))

Optional Riders

- Prescription Drug (CH-26214 (CCHBP/0309) or CH-26214 (SSMB/0309))

Physician Office Visits Rider (CH-26223 (SS 03/09))

- Plan A - Unlimited visits, subject to Base Network/Non-Network Deductible and Coinsurance
- Plan B - Limited to 4 visits, Per Calendar Year; subject to Network and Non-Network Copay
- Plan C - Unlimited visits, subject to Network and Non-Network Copayments

The following forms are underwritten by The Chesapeake Life Insurance Company

ClassicFit (Catastrophic Expense Preferred Provider Organization (PPO) Certificate)

(CH-26210 PPO-C (CCHBP) (03/09)) **CFIL** Family Members 1 2 3 4 5 6 7 8 9 10

Additional Plan Option Elected:
 (CH-26210 PPO-C (SSMB) (03/09)) **CFIH**

Aggregate/Lifetime Maximum:
 Option A: \$1,000,000/\$2,000,000 Option B: \$1,000,000/\$4,000,000 Option C: \$2,000,000/\$8,000,000

Network/Non-Network Deductible:

Per Insured Person, per Period of Treatment	All other Outpatient Covered Services, per Insured Person, per Calendar Year
<input type="checkbox"/> \$1,000/\$2,000	<input type="checkbox"/> \$1,000/\$2,000
<input type="checkbox"/> \$1,500/\$3,000	<input type="checkbox"/> \$1,500/\$3,000
<input type="checkbox"/> \$2,500/\$5,000	<input type="checkbox"/> \$2,500/\$5,000
<input type="checkbox"/> \$3,500/\$7,000	<input type="checkbox"/> \$3,500/\$7,000
<input type="checkbox"/> \$5,000/\$10,000	<input type="checkbox"/> \$5,000/\$10,000
<input type="checkbox"/> \$7,500/\$15,000	<input type="checkbox"/> \$7,500/\$15,000

Network/Non-Network Coinsurance: 80%/60% 70%/50%
Network/Non-Network Coinsurance Maximum: \$5,000/\$10,000 \$10,000/\$20,000

The following forms are underwritten by The Chesapeake Life Insurance Company

Additional Rider

Prescription Drug Expense (CH-26214 (CCHBP/0309) or (CH-26214 (SSMB/0309))

- A \$50 Brand Drug deductible B \$250 Brand Drug deductible

Optional Riders

Pregnancy/Childbirth Benefit Rider (CH-26213 (CCHBP/0309) or (CH-26213 (SSMB/0309))

- Maximum \$1,000/\$2,000 \$2,000/\$4,000 \$3,000/\$6,000

Outpatient Diagnostic Services Rider (CH-26226 (SS 03/09))

- Network/Non-Network Copayment \$100/\$200 \$250/\$500
Maximum per Calendar Year \$2,500 \$5,000 \$7,500

Physician Office Services Rider (CH-26223 (SS 03/09)) 2 visits 4 visits

Outpatient Accident Expense Rider (CH-26221 (SS 03/09))

- Copayment \$50 \$100 \$150
Maximum \$500 \$1,000 \$1,500

Outpatient Speech, Physical, & Occupational Therapy Rider (CH-26224 (SS 03/09))

Continued Care Rider (CH-26225 (SS 03/09))

The following forms are underwritten by The Chesapeake Life Insurance Company

Chesapeake ANCILLARY PLANS

Association membership is Optional

Vision (CH-26023-IP (5/07)) VSIC

(Vision Insurance Policy)

Family Members 1 2 3 4 5 6 7 8 9 10

Dental (CH-26099 IP (1/08))

(Dental Insurance Policy)

Family Members 1 2 3 4 5 6 7 8 9 10

- Gold DTCG
- Silver DTCS
- Bronze DTCB

CancerWise (CH-26055-IP (5/07)) ECAC (Cancer Benefit Policy)

Family Members 1 2 3 4 5 6 7 8 9 10

First Diagnosis Cancer Benefit Amount: \$10,000 (*only available with a health plan*)
 \$20,000 \$30,000 \$40,000 \$50,000

The following plans are underwritten by The MEGA Life and Health Insurance Company

MEGA ANCILLARY PLANS

Association membership is Required

Income Prot. (25916-C) DSGP (Accident-Only Disability Income Insurance Certificate)

Primary \$ _____ Elimination Period _____ days
 Spouse \$ _____ Elimination Period _____ days

Inc. Prot. Plus (25915-C) DIGP (Disability Income Insurance Certificate)

Primary Blue Collar White Collar
Indemnity Benefit \$ _____ Waiver of Premium (25917) Return of Premium (25918)
 Spouse Blue Collar White Collar
Indemnity Benefit \$ _____ Waiver of Premium (25917) Return of Premium (25918)

Accident Advantage Plan (26038-C) ACLG (Accidental Injury Only Insurance Certificate)

Family Members 1 2 3 4 5 6 7 8 9 10
Benefit Amount (Per insured person, per calendar year) \$ _____

Critical Care Plus (25936-C) CI01 (Specified Disease/Condition or Major Organ Transplant Certificate)

Amount \$ _____ Family Members 1 2 3 4 5 6 7 8 9 10
Amount \$ _____ Family Members 1 2 3 4 5 6 7 8 9 10
Amount \$ _____ Family Members 1 2 3 4 5 6 7 8 9 10

Direct Benefit Plan (25874-C) DB01 (Hospital Confinement Indemnity Certificate)

Family Members 1 2 3 4 5 6 7 8 9 10
Amount \$ _____

Accident Catastrophic (25314) GA08 (Accident Catastrophic Expense Plan Certificate)

Family Members 1 2 3 4 5 6 7 8 9 10
Coinsurance _____ % Deductible \$ _____
Accident Expense Benefit Rider (25096) Deductible \$0 \$100 Maximum \$600 \$1,200

MEGA ANCILLARY PLANS

Association membership is Optional

Vision (26023-IP (5/07)) VSIC

(Vision Insurance Policy)

Family Members 1 2 3 4 5 6 7 8 9 10

Dental (26099 IP (1/08))

(Dental Insurance Policy)

Family Members 1 2 3 4 5 6 7 8 9 10

- Gold DTCG
- Silver DTCS
- Bronze DTCS

CancerWise (26055-IP (5/07)) ECAC

(Cancer Benefit Policy)

Family Members 1 2 3 4 5 6 7 8 9 10

First Diagnosis Cancer Benefit Amount: \$10,000 *(only available with a health plan)*
 \$20,000 \$30,000 \$40,000 \$50,000